MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044054 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11883

FILED DEC 14 1962

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF

BY AFFIDAVIT OF / DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4055 St. Ferdinand — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Frank — Middle — Last Byrd

4. DATE OF DEATH: Month 12 — Day 9 — Year 62

5. SEX: Male

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 8-29-1902

9. AGE (last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (City and state or country): Ala.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William Byrd

13b. MOTHER'S MAIDEN NAME: Sarah Betts

14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: Henretta Weathers 4256 Delmar

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c): 331
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from 12-7-62, to 12-9-62 and last saw ~~him~~ her alive on 12-9-62
Death occurred at 8:30 P. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature]
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 12-10-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 12-14-62
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR: E.B. Florence — ADDRESS: 1221 N. Grand
25. DATE RECD. BY LOCAL REG.: DEC 11 1962
26. REGISTRAR'S SIGNATURE: Boal Smith. M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Clarence Adams

Licensed Embalmer No. 4956

P. O. Address 122 Main

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.